UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

HUMIRA (adalimumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext.and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Documented diagnosis of moderate to severely active Crohn's Disease.
- Documented inadequate response to conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, or budesonide).

OR

- Documented intolerance to or loss of response on infliximab (Remicaid).

AUTHORIZATION:

Initial prior is for 6 months for one 6-syringe starter pack and 2-syringe maintenance packs monthly thereafter.

RE-AUTHORIZATION:

Six months of 2-syringe maintenance packs with updated letter of medical necessity.